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Breaking taboos: acknowledging therapist arousal and disgust

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Abstract

In this discussion paper I do not necessarily have answers but I hope to ask some thought-provoking questions about arousal and disgust when they occur in the therapist. These two internal phenomenon seem particularly relevant to my area of specialism of sexual health; however, these experiences might occur for any therapist working with individual adults or couples, and of more concern, when working with adolescents or children. And yet, these experiences are rarely discussed in the literature, supervision, training or staff meetings. My hope is that this paper will inspire further conversations within the reader's work settings to break the silence taboo and improve the quality and safety of our work.

Key Words: Therapist Arousal Disgust

When it comes to a therapist experiencing feelings of arousal or disgust during their clinical work, as practitioners, trainers, writers and researchers we may find it 'exceptionally difficult to acknowledge these feelings' (Pope & Tabachnick, 1993 pg 142). To do so requires us to have a clear understanding and ability to articulate of our emotional and sexual selves, as well as find professional models to understand and talk about this in a professional context. We are ill-equipped to do this as most training programs ignore, discount or inadequately deal with these issues (Pope *et al.*, 1986; Pope & Tabachnick, 1993), as do our colleagues and supervisors (Pope *et al.*, 1986). The notion of therapist arousal and disgust jars with the notion of the therapist as a caring empathic professional who's role is to help those in need (Pope *et al.*, 2005). And yet these feelings are supposedly quite common, as will now be discussed.

Arousal

There is little research into therapist feelings in general, but Pope and colleagues have conducted two studies on therapist attraction. Their survey found that 87% of therapists (95% of men and 76% of women) 'have been sexually attracted to clients ... many (63%) feel guilty, anxious, or confused about the attraction' (Pope *et al.*, 1986, pg 147). In a later study, of the 86.8% describing sexual attraction, 57.9% reported physical sexual arousal in the presence of a client (Pope & Tabachnick, 1993). In the psychodynamic literature, Searles (1959) also has the courage to write about his genital arousal during a therapy session, which left him 'with considerable anxiety, guilt, and embarrassment' (pg 183).

Disgust

When it comes to feelings of disgust, I could find no prevalence data but again the psychodynamic literature provides anecdotal examples. For example, in

Love's Executioner, Yalom (1991) describes his feelings of disgust towards a female client who is very overweight:

'I have always been repelled by fat women. I find them disgusting (pg 87)... The origins of these sorry feelings? I have never thought to inquire. So deep do they run that I never considered them prejudice (pg 88)...

The entire hour with her [the client] was an exercise of my sweeping from my mind one derogatory thought after another in order to offer her my full attention (pg 89) ... Could I be intimate with her? I could scarcely think of a single person with whom I less wished to be intimate (pg 91).'

Of interest is that at the end of the therapy the client revealed that she was aware of his feelings all along and they were able to discuss it:

' "I'll miss our meetings. But I'm changed as a result of knowing you" ...

"What change?" ...

"my attitude about obesity has change a lot. When we started I personally didn't feel comfortable with obese people"

" 'didn't feel comfortable' – that's putting it mildly. Do you know that for the first six months you hardly ever looked at me? And in a whole year and a half you've never – not once – touched me? Not even for a handshake!" ' (pg 115)

de Jong *et al.* (2010) distinguish between 'core' disgust and socio-moral disgust, both of which might be felt by the therapist. Core disgust is an evolutionary phenomena to defend and protect the individual from contamination by pathogens in the environment. Rozin and Fallon (1987) found that bodily products and odours are among the strongest disgust elicitors. The purpose of this reaction is to distance oneself from the pathogen, which is a serious consequence if experienced by the therapist. Socio-moral disgust is argued to protect and internalise a cultures' socio-moral rules and is elicited by behaviours that violate these rules, or for the therapist, hearing about such behaviours (e.g. incest). Wheatley and Haidt (2005) found that hypnotically creating feelings of disgust had the effect of increasing the severity of moral judgement; again of serious consequence if felt by the therapist.

We may consider that disgust and arousal are polar opposites but they might not be, in that an individual might feel disgusted and yet find themselves physically aroused, which might feel shameful to share with others. I also wonder whether disgust is easier for therapists to talk about than arousal, in that disgust reinforces boundaries whereas arousal threatens to violate them.

Therapist responses to arousal and disgust

Once a therapist acknowledges that they may feel aroused or disgusted by their client or the material presented, there are a wide variety of responses

that might be experienced. Common responses cited by Pope *et al.* (2005) include shock, guilt, anxiety, fear of losing control or being criticised, confusion about boundaries, roles or actions or anger and frustration at being unable to act or talk openly about these feelings. All these responses could leave a therapist paralysed to know how to move forward in the therapy safely and to the client's benefit. The denial of these feelings may result in 'therapy that is adapted to the needs of the therapist rather than the needs of the patient' (Winnicott, 1949, pg 74). The therapist may avoid discussing topics that may be central to the therapy, end therapy early or refer the client elsewhere. The therapist might blame the client for their feelings or else blame themselves and on reflection discover that they had behaved towards the client in ways that were exception to their practice. For example, booking appointments out of hours to fit in the client, or else finding themselves double-booking appointments to avoid them. Alternatively, a therapist may avoid talking about a client in supervision or else constantly seek reassurance about their work with them (Pope *et al.*, 2005).

As therapy continues there may be unaddressed tension in the therapeutic relationship (Boccellari & Dilley, 1989), which the client may be aware of but unable to raise or understand. Of concern is that there is a potential for misdiagnosis: Reiser and Levenson (1984) found that therapists who disliked their clients were more prone to applying a diagnosis of Borderline Personality Disorder, even though their clients had none of the listened symptoms of the condition. Most concerning of all is the risk that a therapist may act on their feelings of arousal and sexually abuse their clients (Reiser & Levenson, 1984). In the US, Pope (1990) reviewed the literature and found that as many as 10% of male therapists and 2-3% of female therapists had had sex with a client. Masters and Johnson (1966; 1970) first provide research evidence that this occurs and presented it to the American Psychological Association's annual conference as tantamount to rape, warranting criminal rather than civil punishment (Masters & Johnson, 1975; cited in Pope, 1990). That men violate client boundaries more than women can be tracked back to findings such as men are more likely to touch women than visa versa (Henley, 1973;1977), and findings such as Brodsky's (1977) study which revealed that male therapists reactions to a client's declaration of love were the dilemma of whether to reject or seduce her, compared to female therapists reactions which were concern for her own safety.

Understanding therapist arousal and disgust

However, these feelings of therapist arousal and disgust are potentially understandable when the intimacy and privacy of the therapeutic relationship is considered. When working with clients with relationship or sexual problems, we may have unique conversations with clients in therapy; for example, asking questions such as:

- Exactly how hard does your penis get?
- Exactly how long was it before you ejaculated?
- Show me how far down your finger you were able to penetrate.

- How much labial tissue do you have remaining as a result of the circumcision?

These questions are important to help us build a clear understanding of the problems clients bring to therapy and the solutions that might be possible. But it is important to reflect that we do not have these types of conversations outside of our work context, yet we train our 'professional selves' to model comfort at asking and answering them. However, they are so intimate and private, prior to developing an identity as a therapist our social training was not to ask them. Can we really disconnect our bodies from these discussions when we put on the cloak of 'therapist'?

Arousal / disgust might be experienced as an intra-personal phenomenon (in which case I might worry whether I am revealing it or how I might cover it up), or as inter-personal phenomenon (is the person or material we are discussing causing me to draw back or get too close?). In some ways an interpersonal experience may be easier to talk about in that we do not necessarily have to solely 'own' it, unlike the intra-personal. These feelings may be driven by direct feelings we have about the client in front of us or they may connect to our own memories of gratifying sexual encounters, or of abuse, humiliation or personal experiences of disgust. Similarly, in the course of our work we may build detailed mental images of clients in sexual situations (whether cohesive or consensual) and these may intrude into our private lives, e.g. a sexual act may mirror a client's description of a similar act performed in an abusive context. We may find that thoughts of the client arise unbidden in our most intimate personal experiences.

Acting on feelings of arousal and disgust

Are we able to consider the possibility that coming from a position of respect, warmth and well-intent we might discuss feelings of disgust or arousal with clients? How might we respond if a client were to ask directly what we feel about them? Pope and Tabachnick (1993) suggest that if feelings are 'promptly acknowledged and adequately addressed they may, under certain circumstances, serve as a therapeutic resource' (pg 142). Under what circumstances might this be the case? For example, raising person hygiene with a client with a repulsive odour may have a wider beneficial impact on the client's life. Sexual arousal might trigger a memory for the therapist that might be a resource, for example to widen the definition of 'sex' that the client is using.

Any discussion of a therapist's feelings in a client's therapy should always be from the therapeutic rationale that it is to assist in the client's therapy. The powerful position of therapist in relation to client, and the trust the client has placed in the therapist, exacerbates the risks of the therapist hurting or exploiting the client. The therapist must remain ever mindful of why they are disclosing their feelings and not just do so under the guise of therapeutic procedures, e.g. a chance for the client to hear about their effect on others; being authentic; to model sexual frankness; etc (Pope *et al.*, 2005). Any disclosure should occur in a way that is consistent with the therapist's

therapeutic orientation, to meet a clinical need in the client, and that the therapist is ready to account for why such disclosure occurred (Pope *et al.*, 2005).

If we are to consider having these conversations with clients, we should perhaps first ask whether we feel comfortable taking these dilemmas to supervision, as we certainly need to be accountable for all we do in the therapy room. Therapists may fear that this information about their reaction to a client might be taken out of context or misused/misconstrued (Pope *et al.*, 2005); as was Freud's experience regarding his work on sexuality (Jones, 1961):

'I treated my discoveries as ordinary contributions to science and hoped to be met in the same spirit. But ... the insinuations that found their way to me, caused me gradually to realise that one cannot count upon views about the part played by sexuality ... meeting with the same reception as other communications ... I could not reckon upon objectivity and tolerance.' (pg 177)

Similarly, do we feel comfortable asking about these feelings of a supervisee? Do we feel able or comfortable to work with a supervisor/supervisee to unpick and explore what is being touched in us/them that we are finding disgusting or arousing? Pope *et al.* (2005) hold that it is essential for professional development and practice that 'the complex cognitive (e.g. confusion), affective (e.g. anxiety), and physical (e.g. genital arousal) responses to those feelings' (pg 8) are addressed. These conversations might be more difficult in closer, intimate relationships, such as therapy or supervision because of embarrassment or fear of shame. However, we need to find ways to honestly and openly acknowledge the embodied impact of our work and bring this to discussions with peers, supervisors, supervisees, write about it in research and, where deemed appropriate, share it with our clients. We ask this much of them.

Conclusion

As I stated at the start of this paper, there are no clear answers to the dilemmas raised, indeed, different therapeutic model may provide different and even conflicting advice. Therapists need to use the tools we have available to work through these issues: self-reflection and honesty, literature review, peer-discussion, supervision, and potentially personal therapy (Pope *et al.*, 2005). Warning signs that something is amiss, such as a lack of consistency in communication to the client, need to be attended to as soon as they are noticed. We also need to ensure that we keep space protected to talk about clinical dilemmas such as this, particularly at a time when services seem to be moving towards an emphasis on quantity rather than quality. Moving outside our comfort zone and confronting our clinical dilemmas with colleagues is a catalyst for growth and therapeutic wisdom, even though it might not feel it at the time!

Further reading

K.S. Pope, J.L. Sonne and J. Holroyd (2005). Sexual Feelings in Psychotherapy: Exploration for therapists and therapists-in-training. Washington: American Psychological Association

This book explored in depth issues of sexual attraction experienced by therapists and offers an excellent self-assessment exercise, including questions such as:

‘Can you remember a time during a therapy session that you became privately but intensely aware of your own body? What seemed to lead to this awareness? ...

Can you remember a time during a therapy session that you became intensely aware of the client’s body? What seemed to lead to this awareness? Did the client seem to notice? Did you discuss it with the client?’ (pg 50).

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